FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020628

Facility Name: FOUNTAINVIEW

Address: U.S. ROUTE 45 (Number) ELDORADO (City) 62930 (Zip Code)

County: SALINE

Telephone Number: 618-273-3353 **Fax #** 618-273-4800

IDPA ID Number: 37-1012053001

Date of Initial License for Current Owners: 08-17-1976

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BILLY L. JONES **Telephone Number:** 618-273-3353

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07-01-2000 to 06-30-2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BILLY L. JONES
(Title) TREASURER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) JAMES HENSON CPA
(Firm Name & Address) JAMES HENSON, P.C.
P.O. BOX 280, RIDGWAY IL 62979
(Telephone) 618-272-3931 Fax # 618-272-7105

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	87	Intermediate (ICF)	87	31,755	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	515	3,375	30	3,920	8
9	SNF/PED					9
10	ICF	22,482	15,287	72	37,841	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,997	18,662	102	41,761	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.75%

D. How many bed-hold days during this year were paid by Public Aid? 29 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08-17-1976

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 2,651

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12-31-2001 Fiscal Year: 06-30-2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	120,948	10,986	9,794	141,728		141,728		141,728			1
2	Food Purchase		151,043		151,043		151,043	(3,449)	147,594			2
3	Housekeeping	102,118	25,541	320	127,979		127,979		127,979			3
4	Laundry	39,517	5,637	120	45,274		45,274		45,274			4
5	Heat and Other Utilities			73,174	73,174		73,174		73,174			5
6	Maintenance	21,898	17,827	34,691	74,416		74,416		74,416			6
7	Other (specify):* WASTE REMOVAL			3,121	3,121		3,121		3,121			7
8	**TOTAL General Services**	284,481	211,034	121,220	616,735		616,735	(3,449)	613,286			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	867,290	113,679	15,156	996,125		996,125		996,125			10
10a	Therapy	31,342	47	51,211	82,600		82,600		82,600			10a
11	Activities	33,316	1,907	80	35,303		35,303		35,303			11
12	Social Services	34,471		2,878	37,349		37,349		37,349			12
13	Nurse Aide Training											13
14	Program Transportation		975		975		975		975			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	966,419	116,608	69,325	1,152,352		1,152,352		1,152,352			16
	C. General Administration											
17	Administrative	42,699			42,699		42,699		42,699			17
18	Directors Fees			18,250	18,250		18,250		18,250			18
19	Professional Services			34,588	34,588		34,588	(225)	34,363			19
20	Dues, Fees, Subscriptions & Promotions			6,708	6,708		6,708	(3,599)	3,109			20
21	Clerical & General Office Expenses	63,695	8,537	10,330	82,562		82,562		82,562			21
22	Employee Benefits & Payroll Taxes			189,904	189,904		189,904		189,904			22
23	Inservice Training & Education			2,982	2,982		2,982		2,982			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation		975		975		975		975			25
26	Insurance-Prop.Liab.Malpractice			72,739	72,739		72,739	(12,980)	59,759			26
27	Other (specify):* IL REPLACEMENT TAX			7,382	7,382		7,382	(7,382)				27
28	**TOTAL General Administration**	106,394	9,512	342,883	458,789		458,789	(24,186)	434,603			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,357,294	337,154	533,428	2,227,876		2,227,876	(27,635)	2,200,241			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FOUNTAINVIEW #0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,815	46,815		46,815	28,977	75,792			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,924	14,924		14,924	(9,865)	5,059			32
33	Real Estate Taxes			28,666	28,666		28,666		28,666			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			90,405	90,405		90,405	19,112	109,517			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	16,337	927	80	17,344		17,344		17,344			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,116	74,116		74,116		74,116			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	16,337	927	74,196	91,460		91,460		91,460			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,373,631	338,081	698,029	2,409,741		2,409,741	(8,523)	2,401,218			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,977	30		9
10	Interest and Other Investment Income	(9,865)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,449)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(225)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(12,980)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(200)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,382)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,399)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,523)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,523)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

FOUNTAINVIEW

ID# 0020628

Report Period Beginning: 07-01-2000

Ending: 06-30-2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-2000 **Ending:** 06-30-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,449)	0	0	0	0	0	0	0	0	0	0	(3,449)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,449)	0	0	0	0	0	0	0	0	0	0	(3,449)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(225)	0	0	0	0	0	0	0	0	0	0	(225)	19
20	Fees, Subscriptions & Promotions	(3,599)	0	0	0	0	0	0	0	0	0	0	(3,599)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(12,980)	0	0	0	0	0	0	0	0	0	0	(12,980)	26
27	Other (specify):*	(7,382)	0	0	0	0	0	0	0	0	0	0	(7,382)	27
28	**TOTAL General Administration**	(24,186)	0	0	0	0	0	0	0	0	0	0	(24,186)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,635)	0	0	0	0	0	0	0	0	0	0	(27,635)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-2000 **Ending:** 06-30-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	28,977	0	0	0	0	0	0	0	0	0	0	28,977	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,865)	0	0	0	0	0	0	0	0	0	0	(9,865)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	19,112	0	0	0	0	0	0	0	0	0	0	19,112	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,523)	0	0	0	0	0	0	0	0	0	0	(8,523)	45

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	ALBERT G. BLEDIG	PRESIDENT	EXEC. BOARD	22.97		2		DIR. FEES	$ 3,000	18-3	1
2	DON R. DEARMON	SECRETARY	EXEC. BOARD	22.97		2		DIR. FEES	3,000	18-3	2
3	BILLY L. JONES	TREASURER	EXEC. BOARD	10.29		2		DIR. FEES	3,000	18-3	3
4	BILLY L. JONES	---	BUS. MANAGER	0.00		10		BUS. MGR.	19,000	19-3	4
5	EVERETT KNIGHT	DIRECTOR	EXEC. BOARD	5.83		2		DIR. FEES	3,000	18-3	5
6	ROBERT G. MORGAN	VICE PRESIDENT	EXEC. BOARD	6.56	* 4800	2		DIR. FEES	3,000	18-3	6
7	JAMES B. CHILDRESS	DIRECTOR	EXEC. BOARD	13.12		2		DIR. FEES	3,000	18-3	7
8	DENTON FERRELL	DIRECTOR	EXEC. BOARD	0.00		0		DIR. FEES	250	18-3	8
9											9
10											10
11											11
12	* POPE COUNTY CARE CENTER, GOLCONDA, ILLINOIS										12
13								TOTAL	$ 37,250		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 6-30-2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BANTERRA BANK		X	BUILDING IMPROVEMENTS	$4,500.00	06-20-96	$ 414,988	$ 74,000	09-05-2001	9.5000	$ 14,924	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$4,500.00		$ 414,988	$ 74,000			$ 14,924	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 414,988	$ 74,000			$ 14,924	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 39,113	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 25,732	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,381)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,047	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 28,666	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	20,405	8
	1997	22,200	9
	1998	23,710	10
	1999	25,732	11
	2000	27,428	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

LINE 2 - 1999 PAID IN 2000

LINE 4 - 2000 PAYABLE 2001 $27,428 + 1/2 2001 PAYABLE 2002 $14,619 = $42,047

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOUNTAINVIEW COUNTY SALINE

FACILITY IDPH LICENSE NUMBER 0020628

CONTACT PERSON REGARDING THIS REPORT BILL JONES

TELEPHONE 618-273-3353 FAX #: 618-273-4800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-1-159-04	4.89 ACRES-FACILITY LOCATION	$ 27,428.00	$ 27,428.00
2.		ELDORADO, ILLINOIS	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,428.00	$ 27,428.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,659 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	217,800	1976	$ 21,500	1
2					2
3	TOTALS	217,800		$ 21,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		1976	1973	$ 324,614	$	27	$ 12,023	$ 12,023	$ 307,638	4
5	76		1976	1976	519,630		30	17,321	17,321	447,728	5
6	12		1983	1983	273,457	13,673	30	9,115	(4,558)	161,812	6
7			1993	1993	159,083	3,182	50	3,182		25,721	7
8			1998	1998	17,723	354	50	354		944	8
	Improvement Type**										
9	ROOF			1982	20,564		10			20,564	9
10	ROOF			1988	14,123		10			14,123	10
11	ROOF			1990	10,586		10	438	438	10,586	11
12	LIFT			1991	3,572	179	10	270	91	3,572	12
13	OUTSIDE LIGHTS			1991	1,345		10	119	119	1,345	13
14	ROOF			1991	13,600		20	680	680	6,630	14
15	KITCHEN LIGHTS			1992	1,208		20	60	60	555	15
16	HEATING & AIR UNITS			1992	26,114	1,741	15	1,741		15,379	16
17	ROOF			1992	9,000	450	20	450		3,900	17
18	HEATING & AIR UNITS			1993	7,578	505	15	505		4,124	18
19	FENCE			1993	8,581	429	20	429		3,396	19
20	HEAT & AIR UNIT			1993	2,023	135	15	135		1,057	20
21	HEAT & AIR UNIT			1994	2,777	185	15	185		1,480	21
22	HEAT & AIR UNIT			1994	2,124	142	15	142		1,006	22
23	HEATING & AIR UNITS			1995	5,723	382	15	382		2,419	23
24	HEATING & AIR UNITS			1996	4,050	270	15	270		1,485	24
25	REMODELING			1997	20,514	1,026	30	684	(342)	2,793	25
26	ROOF			1997	35,935	5,134	7	5,134		15,830	26
27	AIR CONDITIONING UNIT			1997	3,375	225	15	225		713	27
28	PARKING LOT & DRAINAGE			1998	44,413	888	50	888		2,368	28
29	DUMPSTER			1998	1,931	97	20	97		257	29
30	ROOF			1998	3,800	543	7	543		1,448	30
31	FIRE ALARM SYSTEM			1999	48,588	2,429	20	2,429		3,846	31
32	KITCHEN REMODELING			2000	7,307	365	20	365		395	32
33	METAL CANOPY			2000	3,508	175	20	175		233	33
34	ROOM NUMBERS & NAME PLATES			2000	1,472	73	20	73		97	34
35	LANDSCAPING			2000	1,411	71	20	71		83	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FIRE SHUTTER & BASEBOARDS	2001	$ 6,991	$ 117	10	$ 117	$	$ 117	37
38	17 HEATERS	2001	2,054	11	15	11		11	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,608,774	$ 32,781		$ 58,613	$ 25,832	$ 1,063,655	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 300,838	$ 8,247	$ 11,392	$ 3,145	15	$ 180,223	71
72	Current Year Purchases	40,957	1,444	1,444		15	1,444	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 341,795	$ 9,691	$ 12,836	$ 3,145		$ 181,667	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	94 FORD WAGON	1997	$ 8,234	$ 823	$ 823	$	10	$ 3,635	76
77	TRANSPORT RESIDENTS	95 CHEVY VAN	1998	12,775	1,278	1,278		10	3,621	77
78	TRANSPORT RESIDENTS	98 FORD VAN	1999	22,422	2,242	2,242		10	4,297	78
79										79
80	TOTALS			$ 43,431	$ 4,343	$ 4,343	$		$ 11,553	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,015,500	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 46,815	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,792	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 28,977	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,256,875	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SEE LETTER ATTACHED TO THIS REPORT

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 **Report Period Beginning:** 07-01-2000 **Ending:** 06-30-2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06-30-2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 459,490	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance NONE)	378,179		3
4	Supply Inventory (priced at COST)	7,930		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,933		6
7	Other Prepaid Expenses	45,244		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 910,776	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	21,500		13
14	Buildings, at Historical Cost	1,608,774		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	385,226		16
17	Accumulated Depreciation (book methods)	(1,455,963)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe A/R	10,692		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 570,229	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,481,005	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 69,486	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	74,000		29
30	Accrued Salaries Payable	72,939		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,580		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,047		32
33	Accrued Interest Payable	124		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,506		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 274,682	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 274,682	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,206,323	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,481,005	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,049,249	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,049,249	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	682,074	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(525,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 157,074	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,206,323	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,112,233	1
2	Discounts and Allowances for all Levels	(35,094)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,077,139	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,252	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,252	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,865	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,865	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	624	28
28a	REFUNDS & MISCELLANEOUS INCOME	1,935	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,559	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,091,815	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	616,735	31
32	Health Care	1,152,352	32
33	General Administration	458,789	33
	B. Capital Expense		
34	Ownership	90,405	34
	C. Ancillary Expense		
35	Special Cost Centers	17,344	35
36	Provider Participation Fee	74,116	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,409,741	40
41	**Income before Income Taxes (line 30 minus line 40)****	682,074	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 682,074	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **T/R ON CALENDAR YEAR**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 39,882	$ 19.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,120	9,675	139,706	14.44	3
4	Licensed Practical Nurses	22,273	23,312	224,338	9.62	4
5	Nurse Aides & Orderlies	62,137	65,423	443,409	6.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,443	3,602	31,342	8.70	8
9	Activity Director	1,916	2,029	15,622	7.70	9
10	Activity Assistants	2,286	2,374	17,694	7.45	10
11	Social Service Workers	4,005	4,180	34,471	8.25	11
12	Dietician					12
13	Food Service Supervisor	1,893	1,997	17,711	8.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,507	16,249	103,237	6.35	15
16	Dishwashers					16
17	Maintenance Workers	2,388	3,095	21,898	7.08	17
18	Housekeepers	14,382	15,134	102,118	6.75	18
19	Laundry	6,024	6,316	39,517	6.26	19
20	Administrator	2,028	2,108	42,699	20.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,221	2,341	29,339	12.53	23
24	Clerical	3,187	3,298	34,356	10.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,825	1,966	19,955	10.15	31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTY SHOP	1,927	2,031	16,337	8.04	33
34	TOTAL (lines 1 - 33)	158,522	167,210	$ 1,373,631 *	$ 8.22	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	202	$ 9,224	1-3	35
36	Medical Director				36
37	Medical Records Consultant	69	3,105	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	900	10-3	39
40	Physical Therapy Consultant	140	6,278	10A-3	40
41	Occupational Therapy Consultant	34	1,541	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	845	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	47	2,798	12-3	45
46	Other(specify) PSYCHOLOGIST	8	950	10-3	46
47	Physical Therapy Consultant	1,281	44,853	10A-3	47
48	Occupational Therapy Consultant	168	5,880	10-3	48
49	TOTAL (lines 35 - 48)	2,011	$ 76,374		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DENISE LUCKETT	ADMINISTRATOR		$ 41,930
REBECCA LONG	ADMINISTRATOR		769
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,699

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BILL JONES	BUSINESS MANAGER	$ 19,000
JAMESTOWN MANAGEMENT	ACCOUNTING SERVICES	4,433
CAROLYN BRUCE	LAND TRUST TRUSTEE	225
JAMES HENSON, PC	ACCOUNTING SERVICES	4,635
LISA HOSKINS	TYPING SERVICES	360
LAMBERT & BEGGS	LEGAL SERVICES	1,106
THOMAS WOLF	LEGAL SERVICES	4,829
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,588

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,760
Unemployment Compensation Insurance	12,105
FICA Taxes	104,077
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT-SEP	6,330
EMPLOYEE CHRISTMAS EXPENSE	1,582
EMPLOYEE VACCINES	527
EMPLOYEE LIFE INSURANCE	1,523
TOTAL (agree to Schedule V, line 22, col.8)	$ 189,904

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,732
Health Care Worker Background Check	976
(Indicate # of checks performed 81)	
Less: Public Relations Expense	( )
Non-allowable advertising	(200)
Yellow page advertising	(3,399)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,109

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number FOUNTAINVIEW # 0020628 Report Period Beginning: 07-01-2000 Ending: 06-30-2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,441** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **74,116**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **NONE**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **72%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

FOUNTAINVIEW, INC. # 002-0628

ATTACHMENT TO PAGE 23 - GENERAL INFORMATION:

QUESTION 12 - 1 EMPLOYEE IS 60% CLERICAL AND 40 % MEDICAL RECORDS.